

4th Annual Report

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

JULY 30, 1976



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NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

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I. INTRODUCTION

Public Law 92-603 of the Social Security Amendments of 1972 mandated the establishment of the National Professional Standards Review Council¹ as a part of the Professional Standards Review Program. The Council, now beginning its fourth year, was chartered in May 1973.

Section 1163(f) of the law requires that the Council report to the Congress and the Secretary of Health, Education, and Welfare, at least annually. This document is the Fourth Annual Report of the National Professional Standards Review Council. It includes a summary of the Council activities and a description of the progress made toward implementing the PSRO program. The report also identifies those issues the Council believes are of major importance to the PSRO program. These will be discussed at the meetings to be held in fiscal year 1977.

II. THE NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

According to the PSRO legislation the Council must be composed of eleven "physicians of recognized standing and distinction in the appraisal of medical practice" who are appointed for a period of three years and are eligible for reappointment. The original members' three-year terms expired June 30, 1976, and a new Council was appointed by the Secretary to serve through June 30, 1979.

The Chairman of the Council is selected by the Secretary from among the Council members. The Director of the Office of Quality Standards (OQS), in the Office of the Assistant Secretary for Health, serves as the Council's Executive Secretary. Staff support for the Council is provided by the Office of Quality Standards.

A. Statutory Responsibility

The duties of the Council are specified in Section 1163(e) of Public Law 92-603 and are as follows:

1. Advise the Secretary in the administration of Title XI, Part B of the Social Security Act relating to Professional Standards Review;

¹hereafter referred to as "the Council."

2. Provide for the development and distribution, among Statewide Professional Standards Review Councils and Professional Standards Review Organizations, of information and data which will assist such review councils and organizations in carrying out their duties and functions;
3. Review the operations of Statewide Professional Standards Review Councils and Professional Standards Review Organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of Part B;
4. Make or arrange for the making of studies and investigations with a view to developing and recommending to the Secretary and to the Congress measures designed more effectively to accomplish the purposes and objectives of Part B.

Additionally, Section 1156 requires the Council, with the Secretary, to provide technical assistance to PSROs in "utilizing and applying norms of care, diagnosis, and treatment." Information about regional norms is to be distributed by the Council to PSROs, and local variations are to be approved by the Council.

The Council makes recommendations on policy issues and provides technical assistance and information to the PSROs, Support Centers, and Statewide Professional Standards Review Councils. Other specific areas of program responsibility include the development of regional norms used by PSROs and the evaluation of PSROs and Statewide Professional Standards Review Councils.

In addition to the PSRO program, the Council advises and assists the Department in the implementation of the Utilization Review (UR) Regulations. The Senate Finance Committee report on Public Law 92-603 provides the basis for this complimentary role. Comments on Section 288 (page 303 of the Senate report) transfer UR advisory responsibility from the Health Insurance Benefits Advisory Council to the Council.

The mandate of the Council, as established in its official charter, is to assist the Department in establishing and implementing policies to determine the medical necessity, quality, and level of care of those services paid for with Federal government funds under Titles XVIII, XIX, and V. This broad mandate has provided the impetus to focus on many other program areas including Health Planning, Long-Term Care, Health Maintenance Organizations, and End-Stage Renal Disease.

B. Operational Procedures

The Council meets approximately six times each fiscal year. The agenda for each meeting is developed, under the guidance of the Council Chairman,

by Council staff after consultation with representatives of the Bureau of Quality Assurance, HSA; the Medical Services Administration, SRS; the Bureau of Health Insurance, SSA; and the Maternal and Child Health Service, HSA. A debriefing session is held after each Council meeting to discuss Council requests for material and to identify issues requiring further development. Council involvement in initial development of substantive policy issues, via presentation of draft papers, is encouraged.

Ad hoc committees of the Council are appointed by the Chairman, for a limited period, to consider more complex issues. After ad hoc committee consensus is reached, the issue is then resubmitted to the full Council with a recommendation for action. Ad hoc committees terminate upon completion of their assigned responsibilities.

Most major policy issues require several meetings for discussion by the Council. Issues may be reintroduced at any time by any member of the Council. Additionally, the Council may identify gaps in areas of PSRO policy and request draft papers and reports. Agreement is reached on most issues through either a consensus approach or formal motions adopted by the Council. It is understood that all policy issues are ongoing, that PSRO is an evolutionary program, and that modifications of all policy recommendations will be made as needed.

C. Nominations for New Membership

The three-year terms of the initial appointees expired on June 30, 1976. The PSRO legislation requires that a majority of the Council's members be recommended by national organizations representing practicing physicians and that members of the Council also include individuals recommended by consumer groups and other health care interests. In early January 1976, a letter from the Assistant Secretary for Health solicited nominations for the Council from national organizations most concerned with PSRO. Nominations were also solicited from the Health Services Administration, the Social Security Administration, the Social and Rehabilitation Service, and the Bureau of Quality Assurance. One hundred and eighty-six nominations for 119 individuals were received from 96 outside organizations and sources. These were reviewed by a nomination committee and their recommended list was approved by the Secretary in June of 1976.

To provide for continuity of leadership, seven members were reappointed. Dr. Merlin K. DuVal, former Assistant Secretary for Health and for three years a member of the first Council, was appointed as Chairman. Rosters of both the old and new Council are included in Appendix 1 and 2.

III. PROGRESS OF THE PSRO PROGRAM

A. Program Implementation

During the past fiscal year, considerable progress was made in the implementation of the PSRO program. PSROs are now in 46 states, including

the District of Columbia and Puerto Rico. At the end of June 1975, there were 65 Conditional and 55 Planning PSROs. Approximately 682 hospitals had reviewed 172,000 admissions. Physician membership in the program numbered 63,500. By June 30, 1976, there were a total of 87 Conditional and 33 Planning PSROs, and Conditional PSROs had implemented review in 2,809 hospitals where approximately 1.25 million admissions (approximately 30% of the total number of Federal admissions in those areas) were reviewed. Total physician membership in the PSRO program is now approximately 80,000.

Thirty-six and eight-tenths million dollars were awarded for PSRO contracts during fiscal year 1976 as follows: new conditionals \$6.8 million, renewal of previously designated conditionals \$25.7 million, planning extensions \$1.5 million, special project and technical assistance \$2.8 million, and renewals of statewide Support Centers \$1 million.

In addition, several important projects were initiated during the spring of 1976. These include: 1) long-term care review, 2) ambulatory care review, 3) technical assistance to PSROs, 4) evaluation of PSRO, and 5) Medicaid and Medicare monitoring.

B. Other Significant Related Activity

1. Legislative Amendment

The Social Security Amendments of 1975, signed by the President on December 31, 1975, provided the opportunity for two significant changes in the program. First, in States with multi-PSRO areas where there were no conditional organizations, the amendments require the Secretary to determine whether a statewide PSRO area is preferred, prior to designating a Conditional PSRO in that State. (This particular change is further explained on the following page under Notification and Polling.)

Second, the amendment extends to January 1, 1978, the limitation on the Secretary to designate a non-physician organization as the PSRO in a particular area. In addition, it similarly extends to January 1, 1978, the requirement of notification and polling.

There are two exceptions to these provisions. The Secretary may designate a non-physician organization as a PSRO if an association, representing the largest number of doctors of medicine in an area or State, adopts a formal policy of opposition or non-cooperation with the PSRO program. For instance, because Nevada has issued a formal opposition to the program, notification is not required to designate a qualified non-physician organization in that State. Furthermore, the amendment allows the Secretary to enter into an agreement, at any time, with a non-physician organization in any area in which an organization has lost at polling. In September 1975, San Mateo, California, became the first PSRO, and it was the only PSRO, to be defeated and terminate as a result of a physician poll.

2. Notification and Polling

The PSRO legislation requires that a notice of intent be given to physicians in a designated PSRO area prior to DHEW entering into an agreement with an organization designated as a PSRO. If more than 10 percent of the area's physicians object on the grounds that the organization is not representative, a poll of physicians in the area must be taken. In fiscal year 1976 there were a number of significant activities regarding the notification and polling process.

The Social Security Amendments (P.L. 94-182), signed by the President on December 31, extended the notification and polling process for two years from January 1, 1976, to January 1, 1978. In addition, the amendments require the Secretary, prior to designating a Conditional PSRO in a State with multiple PSROs but no Conditional PSRO, to conduct a poll among all physicians in the State to determine whether a statewide PSRO is preferred. For there to be a single statewide area, a majority of physicians in the area within the State must favor statewide status.

Potentially six States are affected: Arizona, Indiana, Louisiana, North Carolina, Virginia, and Texas. Texas presents a special problem because of a Federal District Court decision in January 1976 setting aside the multiple PSRO areas that were previously designated in the State.

3. PSRO Review Authority

DHEW Secretary Mathews, in a spring 1976 letter to the Director of the Department of Health in California, reconfirmed former Secretary Weinberger's decision that Conditional PSROs have binding review authority. Should a Conditional PSRO assume the review function in an individual hospital, that review will replace or supercede the Medicare and Medicaid utilization review mechanisms and requirements in that hospital. To facilitate an administrative transition from a previous system to the PSRO system, Medicaid State agencies may request a 60 day period at the beginning of PSRO review, during which time the PSRO's decisions will be recommendations only. In addition, the Department is not requiring, but is encouraging, State agencies to establish and sustain monitoring of PSRO performance.

4. Operational Designation

The Office of General Counsel provided an opinion that a PSRO must conduct both in-hospital and long-term care review to be classified as operational. Furthermore, the Office of General Counsel stated that a Conditional PSRO may enter into another agreement as conditional for another 24 month period for the purpose of extending their review operations into the long-term care area. DHEW is encouraging PSROs and State agencies, particularly Medicaid agencies, to cooperate in the establishment of PSRO long-term care review plans.

IV. NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL ACTIONS DURING FISCAL YEAR 1976

The National Professional Standards Review Council has had significant influence on the PSRO policies developed to date. In the past year, the Council has contributed to the development of data and management information systems policies; a PSRO Program Evaluation Plan; thirty-seven transmittals on such topics as confidentiality, delegated review, and physician certification requirements; and a number of specifications for developing PSRO regulations such as sanctions, advisory groups, and hospital review.

In addition to its PSRO program role, the Council has been requested by the Assistant Secretary for Health to provide advice on a broad range of Departmental activities, as they relate to quality assurance. This request has led the Council to discuss such items as the quality assurance goals of the Health Services Administration and the Health Resources Administration and a variety of other quality assurance issues involving the Health Planning Act, the HMO program, and medical malpractice research issues.

The most important of the Council's deliberations and actions during the last fiscal year are described below.

A. Funding

Funding of the PSRO program was a continuing concern of the Council. For fiscal year 1975, \$37 million was appropriated for the PSRO program. It was not until late February 1976 that the program received its fiscal year 1976 appropriation of \$47.58 million. The Administration, however, had requested about \$50 million. The uncertainty of the appropriation required the Council to consider several alternative contingency plans regarding the rate and method of growth of the program.

In December 1975, the Social Security Act was amended to provide for reimbursement of the cost of directly performing PSRO review on Medicare, Medicaid, and Maternal and Child Health patients in hospitals through the Medicare Trust Funds. Although the amendment provided a much needed relief to the PSRO program budget outlook, the Council still expressed concern over the new amendment's implementation. The Council therefore requested that the staff keep them up-to-date on the amendment's implementation progress.

B. Memorandum of Understanding (MOU)

Memorandums of Understanding were created to delineate responsibilities and assure adequate coordination between the activities of the PSRO and the Medicare fiscal intermediary, the Medicaid State agency, or the Title

V State agency with respect to their mutual responsibilities. Such items as types of review, time schedules, monitoring mechanisms, etc., are included as subject areas of Memorandums of Understanding.

At several of its meetings in fiscal year 1976, the Council explored the efforts of the Bureau of Health Insurance, SSA, Medical Services Administration, SRS, and the Bureau of Quality Assurance, HSA, in developing a model memorandum.

Because of the possibilities for duplication, the Council focused on the type of PSRO monitoring performed by the agencies and the appropriate relationship of monitoring to the PSRO evaluation plan. The Council concluded that technical assistance should be provided to the new PSROs in developing Memorandums of Understanding.

C. Monitoring of the PSRO Program

The Council recognized that both the Bureau of Health Insurance and Medicaid State agencies, as the respective payment agencies for Medicare and Medicaid, should have systems for monitoring the PSRO activity. Regarding the Medicare program, the Council agreed that the monitoring role exercised by the Bureau of Health Insurance is needed, especially during the period of Conditional PSRO designation. The Council concurred with the Medicare proposal to use a system of post-payment review of a percentage of claims for monitoring purposes.

With respect to the Medicaid program, the Council agreed that the States did have a legitimate concern about cost, and therefore the effectiveness of PSRO activities. The Council recommended that any adverse conditions found by the States be reported first to the Medical Services Administration and the Bureau of Quality Assurance for resolution and then, if no satisfactory solution results, to a higher level.

D. Statewide Professional Standards Review (PSR) Councils

Statewide Professional Standards Review Councils (and an advisory group to each Council) are to be established in States which have three or more PSROs. A Statewide PSR Council consists of one representative from each PSRO, two physicians designated by the State medical society (or where there is sufficient osteopathic representation, one designation by the medical society and one by the osteopathic association), two physicians designated by the State hospital association, and four persons knowledgeable in health care selected by the Secretary as public representatives. At least two of the public representatives must be selected from nominees recommended by the governor of the State.

A Statewide PSR Council serves to coordinate the activities of the PSROs within the State, disseminate information and data, assist in the review

of the overall effectiveness of PSRO operations. Councils in six States will be appointed during fiscal year 1976--Massachusetts, Connecticut, New York, Pennsylvania, Maryland, and California. In addition, Missouri, New Jersey, and Ohio are eligible for Statewide Councils and will be appointed in the next year.

The Council discussed the process for developing specific procedures and guidelines for appointing Statewide PSR Council members and establishing Statewide Councils. The Council also reviewed efforts to prepare articles of incorporation and draft model by-laws for use by the Statewide Councils, as well as a draft chapter for the PSRO Program Manual on Statewide Councils.

Concern was expressed over the appropriate relationship between the Statewide PSR Councils and the State organizations required in the Health Planning and Resources Development Act of 1974 (Statewide Health Coordinating Councils), as well as the appropriate relationship between Statewide PSR Councils and Support Centers. Although the Council agreed that the relationships between Statewide Councils and Support Centers would depend very much on individual State situations, they suggested that the PSRO coordination activities, a legislatively mandated function of the Statewide Councils, and the related functions of the Support Centers be clarified. Specifications for Statewide PSR Council regulations were also discussed, and substantive comments were made with regard to osteopathic representation, the methods of nominee selection, the process of incorporation, funding, and the terms of appointment of the Statewide PSR Council members.

E. Support Centers

State Support Centers are organizations that assist in the development of PSRO planning organizations in certain States where there are multiple PSRO areas. Support Centers were originally funded in 13 States. The critical issue with respect to these organizations was whether they should be continued with Federal support beyond their initially scheduled expiration date of June 30, 1976. The Council agreed that it was not desirable to terminate Federal support to all 13 Support Centers and, therefore, recommended revision of the Support Center policy. In those parts of the country where Support Centers exist and where all designated areas do not have PSRO projects, the Council recommended extension of Federal support through fiscal year 1977. Also, to allow for a transition period in those parts of the country where there is Conditional PSRO coverage, direct Federal support will expire September 30, 1976, rather than June 30, 1976. It was generally agreed that the long-run program objective is to eliminate direct Federal support of Support Centers.

F. Sanctions

Sanctions was one of the more thoroughly discussed subjects in the PSRO program. Sanctions are provided to deter improper or inappropriate

Another issue questioned was the enlistment of State governmental organizations to assure compliance by health care practitioners and others. The Council was particularly disquieted by the role of State licensing agencies and the possible ramifications regarding a physician's license to practice. In carrying out any sanctions activity, the Council suggested tightening up the confidentiality aspects for both the patient and the physician. The Council also suggested language clarifications regarding the definition of violations and the actions which provide the opportunity for correction before a violation has been found to have occurred. The Secretary's ability to determine, from sources other than PSRO, that there was a potential problem with an institution or individual practitioner was questioned, and the notification of individuals and institutions regarding sanctions was thoroughly discussed.

After much debate and a redrafting by staff, the Council concurred with the sanctions guidelines for distribution to the PSROs for comment.

G. Physician Certification of Necessity

H. Ancillary Services Review

Ancillary services are defined as those services for which hospital charges are customarily made in addition to routine services. In discussing ancillary services review, the Council agreed that the best type of review system would be a review of the patterns of utilization. Such a review could be accomplished through a variety of mechanisms such as profile analyses and, for selected subjects, Medical Care Evaluation studies. Until profile analyses are fully developed, the Council recommended that already existing information on patterns of care presently stored by Medicare intermediaries and Medicaid State agencies be utilized.

On the payment side, the Council suggested that retroactive denials be avoided, whenever possible, and that the PSROs not retroactively disapprove ancillary services unless prior notice is given to the provider involved.

In further discussion, it was agreed that the problem cases identified through the existing intermediary and State agency process will be referred

the PSRO which will then make a decision on a case-by-case basis regarding payment. The Council was quite sensitive to the need for clarification and direction on ancillary services review, especially in the short range. In their discussions, the Council outlined a short-range approach in

Additionally, they were concerned with the timing of the transition from the short-range to the long-range approach.

The Council suggested that the ancillary services review transmittals be sent to the PSROs for their comment and then brought back for further review.

I. Level of Care

In addition to determining the medical necessity of care, the PSRO has the responsibility for determining if the care can be more appropriately provided at a lower institutional level or on an outpatient basis. The Council discussed the medical necessity of hospital care, the appropriateness of the setting, the patient's eligibility, the relationship between charges and program reimbursement, and the degree to which the involved program covers the services provided. In an attempt to clearly define the various level of care determinations, the Council suggested that PSROs should utilize the Medicare and Medicaid definitions for skilled nursing facility care and Medicaid definitions for lower levels.

The Council agreed that the PSROs should determine what level of care is needed, and if hospital level of care is not needed, the alternative level should be so specified. Should that level of care not be available, the PSRO should advise the payment agency which level of care is appropriate. This procedure would be consistent with a proposed policy encouraging PSROs to work with State agencies and intermediaries regarding level of care determinations. The Council agreed that, from a quality standpoint, it is not appropriate to have review efforts guided by reimbursement policies.

The Council recommended that staff revise and resubmit at a later date the level of care transmittal, taking into account their suggestions.

J. PSRO Liability

The Council reviewed the issue of the liability of PSROs, their officers and employees. There are two legal theories under which a PSRO might be found liable: 1) conspiracy or defamation, in the case where a practitioner's privileges were restricted and 2) negligence, in the case where criteria development or application led to patient injury. These theories have

been explored by staff of the Bureau of Quality Assurance, by the Joint Commission on Accreditation of Hospitals, and by the American Association of PSROs, and there is agreement that while the potential for liability of PSROs is not likely to develop. Reasons for this general conclusion

It is nevertheless reasonable that in the present "malpractice" environment, physicians should wish to minimize any perceived risk of liability. It was for this reason that the Bureau, along with AAPSRO, searched for a professional liability insurance carrier willing to insure against possible risk. A carrier was found in December 1975, and PSROs are currently able to obtain adequate coverage at moderate price. Coverage at a reasonable rate is an allowable contract item in the agreement between the PSRO and the Department.

With coverage reasonably assured, the Council requested that it be kept informed of any important developments regarding this issue.

K. Minority Participation in PSRO

An ongoing concern of the Council was minority participation in PSRO activities. On several occasions the Council discussed the need for PSROs to meet their civil rights responsibilities in the area of employment practices and total review activities of the PSROs.

As a result, and with considerable input from the Council, a transmittal was developed and disseminated to PSRO planning, conditional and Support Center organizations communicating their respective responsibilities regarding civil rights.

The civil rights approach taken by PSROs will be to follow the already existing civil rights legislative and regulatory requirements; specifically, Executive Order 11246, which stipulates that "Federal contractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex or national origin." The order also requires affirmative action in order to ensure equitable opportunity and treatment in employment.

Additionally, PSROs will comply with Section 1152(b)(1) of Title XI of the Social Security Act, which states that membership of a PSRO must not restrict eligibility of any member from service as an officer of a PSRO or from assignment of duties to a PSRO.

Section 1155(d)(1) and (3) require a PSRO to encourage all practicing physicians in its area to participate as reviewers and to assure that

review committees have the broadest representation feasible in terms of the various types of practice indigenous to the area. Therefore, the effective implementation of PSRO review requires the active involvement and participation of minority groups and women.

In summary, the Council supported affirmative civil rights action regarding both the staffing and professional review functions of PSRO organizations and concurred with systematic monitoring and reporting requirements on such civil rights activities as prerequisites of overall PSRO program assessment.

L. Medical Officers (MOs) - Far East

American Samoa and the Trust Territory of the Pacific Islands are components of the Pacific PSRO area. While the governors of these areas are appointed by the President and serve under the Department of Interior, the actual government is local, not Federal, in operation. The governments of these two areas do not individually license doctors to practice medicine or osteopathy in these geographic areas. They do contract with a limited number of M.D.s and D.O.s to work under salary to provide medical services on the islands.

Though they are not doctors of medicine or osteopathy, medical officers are licensed to engage in the practice of medicine or osteopathy. The medical officers are the major providers of medical care in American Samoa and the Trust Territory. (The other two Pacific PSRO components, Guam and Hawaii, have no medical officers.) MOs are licensed by the health components of these governments to practice medicine, and MOs perform the same types of service as do general doctors of medicine and osteopathy, including surgery. There are no legal limitations on what services or procedures may be performed by an MO. In practice, the services or procedures performed are often limited by availability of medical equipment and facilities and proximity to M.D. consultants. The MO is a salaried civil servant of the local (not Federal) governments who is required by law to limit his practice of medicine to patients seen within that government service.

The Pacific PSRO and the Governor of American Samoa have made separate requests that medical officers practicing in American Samoa and the Trust Territory of the Pacific Islands be permitted full membership in the Pacific PSRO. DHEW's General Counsel has rendered an opinion that under the legislation, MOs are not eligible for membership. A technical amendment to Title XI would be the only way that MOs could become members. The issue presented to the Council was whether a technical amendment to the legislation to allow MOs in these areas to become PSRO members should be offered or whether alternate methods to deal with this unique problem should be pursued.

The Council was sympathetic toward the problems of the Pacific PSRO, but at the same time was concerned over the overall implications of an amendment. The question of whether the allowance of MOs to become PSRO members could be interpreted in such a way as to extend PSRO membership to other types of non-physician health care personnel (e.g., physician assistants, etc.) was the major reason for this concern.

After considerable debate, the Council decided that program flexibility, (e.g., recognizing that MOs in American Samoa and the Trust Territory are the legal equals of doctors of medicine and osteopathy in other States), was one of the most important objectives of the implementation of PSRO. The Council, therefore, recommended that DHEW pursue the technical amendment permitting MOs to become members of the Pacific PSRO.

M. Criteria Development

One major aspect of the PSRO program was the development of criteria to be used as guidelines for local PSROs. A number of major contracts were entered into with various national organizations to provide model screening criteria sets for distribution to the PSROs.

1. American Medical Association (AMA) Contract

The primary contract for criteria development was given to the American Medical Association in 1975. During fiscal year 1976, the Council recommended extension of the AMA contract for another six months to consider several aspects of an evaluation of the use of the sample criteria. They discussed the contract progress and, specifically, the sub-contract with Blackstone Associates, who conducted an evaluation of the AMA criteria sets.

With the input of the Blackstone Associates' evaluation, the Council approved republishing the sample criteria sets. The Council's modifications included a revision of the introductory material and specific examples of how the criteria sets may be used in concurrent review and MCE studies. The Council concurred with an expansion of the subject index and a consolidation of overlapping diagnoses in the document. After considerable discussion, the Council moved to support publication of the revised document as part of the existing AMA contract.

At the conclusion of the two year project, the Council accepted the AMA criteria sets and approved modifications which allowed for subsequent revision and easier use of the criteria sets. The criteria were sent to PSROs, Support Centers, State and county medical societies, and all hospitals in the country to be used as samples upon which local review groups could base their criteria sets.

2. American Nurses' Association (ANA) Contract

In July 1974 the ANA was contracted to develop model sets of screening criteria for evaluating the quality of nursing care. The Council discussed the criteria development process proposed by the ANA, and the three evaluation studies undertaken to address validation, consistency of ratings, and the issue of whether the criteria could be used for screening patient records to assess the quality of nursing care.

Major modifications in the criteria guidelines manual were requested by the Council. These changes included: 1) identifying the focus of the manual, 2) clarifying the use of outcome criteria, 3) elaborating the rationale for the focus on outcome criteria, 4) emphasizing that the criteria included were only samples, and 5) changing the definitions to conform with the PSRO definitions. The revised guidelines for review of nursing care, including the sample criteria, were approved by the Council as a form of technical assistance to be distributed to PSROs.

3. American Osteopathic Association (AOA) Contract

The contract with the American Osteopathic Association was primarily established for osteopathic review and comment on the criteria set developed by the American Medical Association. The Council reviewed the AOA contract which included the development of five AOA criteria committees in the areas of general practice, surgery, internal medicine, obstetrics and gynecology, and pediatrics. The Council concurred with the modifications made by the AOA in the AMA criteria sets, as well as the criteria sets specifically related to osteopathic practice, and accepted the American Osteopathic Association criteria set.

4. American Podiatry Association (APA) Contract

Another criteria contract was given to the American Podiatry Association to develop model criteria sets for assessing the quality of podiatric care. The Council reviewed the models assessed by the American Podiatry Association, commended the association for its efforts, and accepted their criteria sets as a form of technical assistance to be disseminated to PSROs.

5. Council Role in Norms, Criteria, and Standards

Section 1156A of Public Law 92-603 mandates a major role for the Council in the establishment and use of norms, criteria, and standards by individual PSROs. The Council is responsible for disseminating regional norms and model criteria and standards to be used by the PSROs as principal points of reference in the establishment of area norms, criteria, and standards for concurrent review in the PSRO area. In addition, the Council must approve area variations in norms, criteria, and standards. To effect this review, the Council must analyze the area norms, criteria, and standards

submitted by the individual PSROs and determine if any vary significantly from the established models.

A number of issues regarding this legislative mandate were discussed by the Council. These included: 1) what regional norms and model criteria will be used for comparison, 2) how will the Secretary identify major variations in norms, criteria, and standards, and 3) on what basis will the Council determine the acceptability of the variations. It was determined that the definition of the term "regional" was critical to an understanding of the Council's role. After some discussion, General Counsel advised that there are two uses of the term "regional." The first relates to the individual PSRO development of its own norms and criteria and refers to sub-areas within a PSRO area. The second relates to the Council's role in distribution of norms and criteria and refers to an area which would be larger than an individual PSRO area.

The Council suggested that the procedures for determining the significance of the variation depended upon whether norms, criteria, or standards were compared. For example, one approach discussed for determining significant variations among criteria was based on using selected diagnoses and comparing the criteria of those diagnoses against available models and/or against criteria for the same diagnoses from other PSROs. The Council agreed that they needed to fully understand the reason for variance between PSROs, particularly with respect to admission rates and length of stay.

The Council directed staff to prepare a document that outlines Council procedures for determining appropriate variation in norms, criteria, and standards. This would be a principle item for consideration by the Council in the coming year.

N. Data and Evaluation

1. Data

a. Confidentiality

Data confidentiality was a major concern of the Council during fiscal year 1976. The legislation explicitly refers to the handling and confidentiality of PSRO data. Section 1155(a) requires that data be held in confidence and limits disclosure to purposes of the act or as the Secretary shall provide in regulations, and Section 1166(b) proscribes a fine and/or imprisonment for unauthorized disclosure. In response to these legislative requirements, draft confidentiality guidelines for the PSRO program were prepared and presented to the Council. Of most concern was the issue of where to draw the proper balance between program disclosure--the patient/consumers need to know when a physician or institution's health care practices are considered to be inappropriate--and the patient's or institution's interest in confidentiality.

The Council was uneasy over former Secretary Weinberger's approval of the Social Security number as the personal identifier for both patient and physician in a Federal collection of the Uniform Hospital Discharge Data Set (UHDDS). The Council wanted to be assured that the data policies for the PSRO program would be designed to protect privileged information contained within the PSRO system, including UHDDS identifiers.

After offering several modifications to the guidelines, the Council recommended that the draft confidentiality guidelines be distributed to the PSROs.

b. Uniform Hospital Discharge Data Set (UHDDS)

In June 1974, the Secretary of Health, Education, and Welfare approved a Uniform Hospital Discharge Data Set as a requirement for the Medicare, Medicaid, and PSRO programs. The data set is based on the multi-purpose minimum basic data set on hospital discharges recommended by the Uniform Hospital Abstract Form Subcommittee of the U.S. National Committee on Vital and Health Statistics. In order to execute the Secretary's decision, an implementation plan for the collection of the UHDDS was formulated by the three programs. Because the implementation significantly affected existing health data collection mechanisms, the plan was sent for comment to the interested individuals and organizations on December 30, 1975, and published in the Federal Register on January 16, 1976.

The Council voiced several concerns over the proposed plan. First, citing the need for data confidentiality safeguards, the Council objected to the use of the Social Security number as a physician and patient identifier. Second, the Council urged that some flexibility be shown at the local level with respect to diagnostic and procedure coding. The fixed format requirement was the final concern of the Council. It was suggested that such a format would not take full advantage of many of the existing data collection systems.

The Council was informed that over 400 comments were received by the Department on the implementation plan and that these comments were being analyzed for presentation to the DHEW Health Data Policy Committee (HDPC). The Council requested a copy of the completed analysis and that they be informed of the HDPC's recommendations.

c. Technical Assistance Documents

As a part of the program's implementation, a number of documents were prepared to provide technical assistance to the developing PSROs. Two such documents were the Technical Assistance Materials for Implementation of the PSRO Data Routing and Processing Policies and the Accounting System for PSROs. The first document includes guidance on how to perform area wide analyses to identify existing data systems, scheduling for phasing

hospitals into the data routing and processing system, determination of cost components, developing data agreements and subcontracts, developing forms, etc. The Council suggested that the relationship between the data policy issues and constraints and their actual application be emphasized, and that PSROs be given some advice regarding specific outside data vendors. The Council concurred with the proposal that the data policy material be reviewed in the field and modified, as necessary, over the next several months. They also recommended an evaluation of both the data routing and processing policy and the technical assistance materials.

The accounting manual is a recommended system of accounts and procedures to meet the PSRO financial needs both internally and externally. The system is not mandatory. The Council approved of the voluntary approach and agreed that information on the design and functions of typical accounting systems would be helpful to PSROs. Additionally, they suggested that the Department test the accounting system with a sample of three PSROs (a very small PSRO, a very large PSRO, and a PSRO that would be an off-shoot of a foundation).

2. Evaluation

a. PSRO Program Evaluation Plan

The evaluation of the PSRO program is a legislatively mandated [Section 1163(e) and (f)] function of the Council. In addition, the Council has stated that such an evaluation is necessary because of the substantial impact PSROs can have on Federal health expenditures; its potential impact upon the entire health care system, in particular, as it relates to the practice of medicine; the need to gain a better understanding of the implications of the different quality assurance system prior to the anticipated implementation of a National Health Insurance program. During both fiscal years 1975 and 1976, the Council has been deeply involved in the development of a plan to evaluate the program. The Council approved the program evaluation plan at its September meeting. The plan included a list of the most important evaluation issues, study protocols for each issue, data requirements, diagnoses and procedures selected for the evaluation, an implementation schedule, and a budget. Of particular concern to the Council was the selection of the diagnoses and procedures, the collection of adequate baseline (pre PSRO) data, and implementation funding.

The first phase of the evaluation plan implementation was approved by the Council at the September meeting. The focus of the initial evaluation effort will be 1) impact of concurrent review in hospital utilization, 2) the cost of PSRO and UR activities, and 3) the effectiveness of the Medical Care Evaluation studies. A report based on the results of this effort and other available independent studies was scheduled for publication by the Council in June 1977. The Council also informed staff that it wished to be kept informed of the evaluation effort.

b. Quality Assurance Systems Study

On June 30, 1975, DHEW contracted with the Institute of Medicine to conduct a study of past and present systems for assuring the quality of medical care. The contract stemmed from the legislative requirement contained in Section 4(a) of the Health Maintenance Organization Act of 1973 (P.L. 92-222).

The major portion of the study is devoted to an evaluative assessment of past and present quality assurance systems, a report of critical gaps in knowledge which require further research and evaluation, and a discussion of the implications of the foregoing for quality assessment in the immediate future.

The second activity, the reabstract study, is a determination of "whether utilization data obtained through hospital use of group discharge abstract services can be used for baseline data in assessing the national impact of the PSRO program."

Nine priority areas are included in the study as follows: 1) outcome oriented quality assurance systems, 2) quality assurance for long-term and ambulatory care, 3) impact on physician behavior, 4) costs of conducting review in systems shown to be efficacious, 5) impact of methods for influencing performance (sanctions, continuing education, peer pressure, etc.), 6) effectiveness of alternative approaches for retrospective patient care evaluations, 7) evidence of effectiveness of various systems, 8) techniques of influencing consumer behavior in the selection of medical services which are appropriate and of high quality, and 9) data systems used by existing review systems and their adequacy for program evaluation.

Information for the study is to be obtained from published and unpublished literature and selected site visits. Upon request, the Council agreed to recommend specific sites to the Institute.

Of major concern, however, was the priority area dealing with techniques of influencing consumer behavior. The Council was uncertain as to whether the objective was to determine how a consumer could be influenced to make a particular provider choice or how a consumer actually makes the choice. It was suggested that the latter interpretation be the appropriate one for the study.

The Council agreed with the selection of services included in reabstract study (PAS, QAP, QUEST, California Health Systems, and several other major hospital systems) and the sample approach based upon a stratification of the following eight variables: 1) the nine census divisions, 2) bed size, 3) the number of Medicare, Medicaid, and Maternal and Child Health claims, 4) medical school affiliation, 5) urban and rural hospital situation, 6) JCAH accreditation, 7) ownership, and 8) the number of beds per population over 65.

The Council requested the staff to keep them informed of the progress of the study.

O. Training

In order to appropriately train the personnel needed for implementation of the PSRO program, the Bureau of Quality Assurance let two training contracts. The Council reviewed the contracts, one with the Institute for Professional Standards, San Joaquin, California, and the other with the Health Care Review Center, Seattle, Washington.

1. Institute for Professional Standards (IPS)

The Institute for Professional Standards conducted ten training sessions in various locations in the country. The sessions focused on review requirements and methodology, the responsibility of PSRO personnel for management of PSROs, the management of Federal contracts, reporting, monitoring, etc. As a part of the course, training session participants made site visits to PSROs and to hospitals currently performing review. Almost 300 individuals, most of whom were employed by local PSROs, were trained under this contract.

The Institute also designed and pilot tested three short-term workshops on legal considerations, PSRO monitoring, and on a methodology for training PSRO personnel.

2. Health Care Review Center (HCRC)

The Health Care Review Center, Seattle, Washington, in cooperation with the Office of Research in Medical Education, University of Washington, School of Medicine, was awarded a contract in May 1975 to develop a model training program for health care review coordinators.

The initial training program was developed and field tested on a class of 15 coordinators. It was revised and retested with a second class of 17 coordinators. The experiences gained in those classes provided the basis for the subsequent training guide.

P. Organizational Issues

1. Office of Quality Standards

During fiscal year 1976, the Council was informed that the quality assurance activities within HEW had been reorganized. This change was published in the October 20 edition of the Federal Register. In essence, the Office of Professional Standards Review (OPSR) was replaced by the Office of Quality Standards (OQS) and given a broader mandate to coordinate an overall quality assurance strategy for the Department. The PSRO program and the

function of Executive Secretary to the Council remain the primary focus of the office. Coordination of other programs and special projects dealing with quality assurance have been added. In addition, the operational responsibility for implementing the PSRO Program Evaluation Plan was transferred to the Office of Policy, Evaluation, and Legislation in the Health Services Administration. OQS, however, will continue to oversee the evaluation implementation.

2. Regionalization

Regionalization, that is, assigning the Regional Offices more substantive and clearly defined responsibilities for program management, has been a policy vigorously pursued by the Administration. Plans for regionalization of the PSRO program were presented to the Council. The plans included a gradual transfer of the day-to-day PSRO project management responsibilities to the Regional Offices, while the Central Office assumes more of a project evaluation and monitoring role with the authority to determine project status (conditional or operational).

The Council requested that it be informed periodically of the regionalization progress.

Q. PSRO Relationships With Other DHEW Health Programs

Because quality assurance has no program boundaries, the activities of the Council have included PSRO relationship discussions with a number of other current or proposed HEW health programs, for example, utilization review for Medicare and Medicaid, the HMO program, the End-Stage Renal Disease program, Health Planning, National Health Insurance proposals, and the Medical Practice Achievable Benefit Project.

1. Utilization Review (UR)

On November 29, 1974, regulations relating to utilization review procedures for hospitals, as conditions for participation in the Medicare program, were published in the Federal Register (39 FR 41604). These regulations were originally to have been effective on February 1, 1975. On April 1, 1975, a notice was published in the Federal Register (40 FR 14591) retrospectively changing the effective date of the regulations to July 1, 1975. As a result of a preliminary injunction issued on May 27, 1975, by the United States District Court for the Northern District of Illinois in the case of American Medical Association vs. Weinberger, affirmed by the United States Court of Appeals for the Seventh Circuit on July 22, 1975, the effective date of portions of those regulations, as well as companion Medicaid regulations, dealing with review of admissions and certain other matters [20 CFR 405.1035(e) and (f) and 45 CFR 250.19(a)(1)(viii)], was delayed until further notice (40 FR 33033, 33036). Thereafter, on September 10, 1975, the Department announced its intention of revising the

regulations and of issuing a new notice of proposed rulemaking (40 FR 42006). The Department also indicated that the law suit was dismissed by joint stipulation of the parties. At the same time, the Department announced that when a final rule was published upon the basis of the new notice of proposed rulemaking, the present language of 20 CFR 405.1035(e) and (f) and 45 CFR 250.19(a)(1)(viii) would be withdrawn and replaced by the new rule. The proposed regulations were published on March 30, 1976.

Because of the close interrelationship between these regulations and the PSRO review system (both would be in effect simultaneously until all PSROs are performing review), the Council had a continuing interest in the development of the regulations. The Council agreed that the basic objectives of the modified regulations, to improve the UR system being implemented across the country, to make the UR process uniform for Medicare and Medicaid, and to make the UR system compatible and as supportive of PSRO as possible, were sound. Of particular concern was the remote facilities variance aspect of the regulations and the issues related to PSRO final review authority. The Council also discussed the utilization control program for Medicaid, specifically, the on-site validation surveys and the penalty study which the Department has undertaken. The Council discussed the proposed rules for UR which were published March 30, 1976, and indicated their general agreement with most of the included provisions.

2. Health Maintenance Organizations (HMOs)

The Council reviewed the quality assurance aspects of Health Maintenance Organizations. In particular, the Council concerned itself with the recent actions of the House of Representatives to extend the present HMO program for two years, improve HMO implementation, and make operating HMOs more competitive with other parts of the health system. Among the provisions highlighted were the elimination of the open enrollment requirement, benefit changes, waiver of the community rating of HMO premiums, available loan guarantees for non-profit HMOs with the priority for medically underserved areas, and the choice of membership requirements.

The Council requested that staff continue to monitor the quality assurance aspects of the HMO program.

3. End-Stage Renal Disease (ESRD) Program

The basic objectives of the ESRD program are 1) to assist beneficiaries who have been diagnosed as having ESRD to receive the care they need, 2) to encourage proper distribution and effective utilization of ESRD treatment resources while maintaining or improving the quality of care, and 3) to provide the flexibility necessary for the efficient delivery of appropriate care by physicians and facilities.

The ESRD Medicare program specifically reimburses most of the cost for two specific therapies---kidney dialysis and transplantation. The prevalence

of kidney patients eligible for Medicare benefits will increase over the next decade from a current entitlement of approximately 26,000 patients to 50,000-60,000 patients with a potential cost of approximately \$1 billion.

The Council was most concerned with the mandated participation of ESRD providers in medical review activities. With many of the objectives of the ESRD program similar to the PSRO program, the Council reviewed the proposed network designations to determine how well they coincided with the HSA and PSRO areas.

The Council commented on the history of funding categorical disease oriented programs and the possibility that the ESRD program may encounter the same problems. They suggested that over a period of time, minimum utilization rates might prohibit new facilities, providers, or practitioners from entering into the system because of an inability to initiate a new program in an area with little apparent need.

4. Health Planning

The new health planning legislation, "The National Health Planning, Resource, and Development Act of 1975," was of particular interest to the Council because of the natural and legislative interrelationship.

The Council strongly recommended that a working liaison be established between the Bureau of Health Planning and the Bureau of Quality Assurance, as well as with the other affected elements of the Public Health Service. The Council reviewed the establishment of the National Council on Health Planning; guidelines regarding the supply, distribution, and organization of health services; and a statement on national health planning goals, all required by the Health Planning legislation.

The Council expressed concern over the lack of coterminality between the designated Health Systems Agencies and PSRO areas and the problems of data sharing between the two programs. In reviewing area designation and redesignation, the Council suggested that HSA program officials might reconsider changing their areas, perhaps to conform more with PSRO areas. They did, however, believe that individual PSROs could, without major problems, relate to more than one HSA. The Council agreed that a primary goal of both programs was to avoid duplication of any data systems and that data confidentiality was a major problem. PSRO generated quality of care and utilization of services studies were one type of data suggested as useful to health planners in developing a health system plan or an annual implementation plan.

The Council recommended that a transmittal be sent to PSROs describing HSA functions, as soon as the health plan regulations for HSAs were published. The Council considered it appropriate that PSROs review and comment on health systems plans and annual implementation plans, especially in the areas of quality care and utilization of services and facilities.

Other items of continuing Council interest were the unique problems of multiple State planning agencies, certificate of need, the role of the governor in recommending the designation of HSAs, and the relationship of PSROs to the State Health Planning and Development Agencies and the State Health Coordinating Councils (SHCC).

At one of its meetings, the Council reviewed a DHEW study on the future HSA/PSRO relationship. The Council acknowledged that HSAs and PSROs would impact on each other whether the agencies consciously sought a relationship or not. The review focused primarily on 1) the role of PSROs in HSA decision making, 2) information flows between the agencies, and 3) the differing obligations of physicians to individual patients and planners to communities as a possible source of conflict. Recognizing that HSAs and PSROs have different priorities and different functional and legislative mandates, the Council reiterated that cooperation should be stressed in the HSA/PSRO relationship. The Council recommended that HSA and health planning development continue to be monitored by the staff.

5. National Health Insurance

a. Quality Assurance Mechanism

At the November 1975 meeting, the Council addressed the issue of a quality assurance mechanism for National Health Insurance (NHI). Six major NHI bills were reviewed and discussed. The Council concluded their debate recommending that PSRO be utilized as the quality assurance mechanism in any NHI plan.

b. Rand Health Insurance Study

At the March 1976 meeting, the Council was briefed on the Rand Health Insurance Study. The HEW funded study was designed to determine the effect of different cost sharing arrangements on demand for health care services. The Council reviewed the basic research design decisions, particularly those relating to the level of quality of care received by enrollees. The Council again reiterated its concern for a viable quality assurance mechanism in NHI.

6. Medical Practice Achievable Benefit Project

One of the unique and most significant items discussed by the Council in fiscal year 1976 was a demonstration project undertaken by the Office of Quality Standards in connection with the six quality assurance goals of the DHEW Forward Plan for Health. The project, tentatively termed the Medical Practice Achievable Benefit Project, has two purposes: 1) the determination of health benefits that are currently being provided against those that could be provided for a specific disease and 2) the determination to the extent possible of the validity of information available about the disease. As this information is developed, it will be presented to the

Council and, if warranted, disseminated to the PSROs for their use in establishing priorities for standard setting and Medical Care Evaluation studies. The project will focus on three areas of investigation, namely, breast cancer, hypertension, and depression. The project is being done in cooperation with ADAMHA, NIH, and HSA.

The Council agreed that the PSRO can play an important role as a vehicle for the transmission of such information. In addition, the Council agreed that there is a tremendous problem relating the relevance, validity, and accessibility of essential medical science information required for developing validity, therapeutic efficacy, and other kinds of information essential for developing standards to assess medical care. They agreed that there needed to be a shift in the basis for decision making in medical practice from primary reliance on incompletely validated information toward proven scientific knowledge.

The Council concurred with the project's intent to identify available information concerning specific disease entities, to rate that information as to its validity and reliability, and to document the source of the information. The Council also expressed the desire to be kept informed of the progress of the project.

R. External Relations

As indicated in previous annual reports of the Council, the support of the nation's physicians and other interested health, medical, and consumer groups is paramount to the development and implementation of the PSRO program. Because of this need, the Department has developed those external relationships that would provide the cooperative environment needed for further development of the PSRO program. Several major groups were involved. Among those addressing the Council during fiscal year 1976 were the Joint Commission on Accreditation of Hospitals, Non-Physician Health Care Advisory Groups, and the American Association of PSROs.

1. Joint Commission on Accreditation of Hospitals (JCAH)

Dr. John Porterfield, Director of JCAH, met with the Council to discuss the apparent hospital confusion over JCAH and PSRO Medical Care Evaluation study requirements. The problem was that JCAH, as a part of its hospital accreditation program, and PSROs, as a part of their hospital review system, set differing requirements for hospital performance of MCE studies. Clarification of what is an acceptable MCE, how it should be performed, and the number required was needed from both JCAH and the PSRO program. Both the Council and Dr. Porterfield expressed the desire to work towards the highest possible degree of harmony and congruity between the programs.

The Council concurred with the JCAH intent to explicitly define criteria and standards as representing optimal achievable care. They also stressed that there be compatibility in definitions and numbers of MCEs performed by both the JCAH and the PSRO program. The Council agreed that the number of admissions was perhaps the best index for determining the number of MCEs required within a given year. The Council also reminded both BOA and JCAH that the quality of the Medical Care Evaluation studies and actual improvements in the quality of care were more important than the number of MCEs performed.

The Council then recommended that BOA and JCAH meet, in the very near future, to resolve the remaining differences.

2. Non-Physician Health Care Liaison Network

An issue that received considerable Council attention was the determination of the most appropriate mechanism for obtaining non-physician practitioner participation and advice in the administration and development of the program. In initial discussions, the Council acknowledged the lack of a formal means for communicating with the non-physician practitioners. The large number of formal organizations representing non-physician practitioners was mentioned as a principal reason for this situation. The Council also questioned how such a diverse group of organizations could be equitably represented (membership) and financed. However, recognizing the need for non-physician practitioner involvement, the Council requested staff to prepare a paper outlining the options available.

Four basic options emerged: 1) establishment of a national advisory committee of non-physician health care practitioners to the Council as recommended in a formal proposal from the American Occupational Therapy Association, 2) establishment of an advisory council of non-physician health care practitioners to meet separate from the Council, 3) establishment of a liaison network of professional representatives from the major national non-physician practitioner organizations, and 4) establishment of other less formal mechanisms such as the use of consultants or an invitational annual conference.

The Council also was informed that many of the non-physician practitioner organizations were willing to try the informal liaison network approach. After much discussion, the Council recommended the third option, establishing an informal liaison network, with one spokesperson selected by all the major non-physician practitioner organizations and representing the network at all Council meetings and acting as a focal point for the program administrators. The Council also requested staff to monitor and evaluate the informal network.

3. American Association of PSROs (AAPPSRO)

At its September 1975 meeting, the Council gave recognition to the formation of the American Association of PSROs, the purpose of which is to provide

individual PSROs a national communication and educational focal point. The AAPSRO held its first annual meeting in San Francisco in August 1975 with 97 PSROs represented.

Later in the year the AAPSRO, representing the Conditional PSROs, briefed the Council on some of their more successful, as well as frustrating, implementation experiences. Problems and potential solutions regarding criteria development, MCE studies, delegation, and memoranda of understanding were discussed.

V. NATIONAL COUNCIL PLANS FOR FISCAL YEAR 1977

Fiscal year 1977 will be a year of significant growth for the PSRO program. Nearly all designated PSRO areas will be involved in PSRO activity; about 60% will be Conditional PSROs and, based on PSRO implementation plans, approximately 4 million of the Title XVIII, Title XIX, and Title V annual admissions will be reviewed. In essence, the program will move from one that has been primarily developmental to one that is primarily operational. Consequently, the program will focus heavily on the performance of the hospital review system, continued improvements in physician acceptance, hospital acceptance, and acceptance by State governments of the PSRO activity. It will also mark the initiation of a comprehensive program evaluation.

The changes brought about by the legislative amendments will become more manifest in fiscal year 1977. The results of the redesignation polls could alter the number of designated PSRO areas. The designation of non-physician organizations as a PSRO will be a possibility for the first time, and the implementation of new PSRO review reimbursement regulations will be in effect.

Fiscal year 1977 will result in a further conversion of the PSRO guidelines manual to regulations, as well as the development of long-term care and ambulatory care review systems. A more precise explication of the Council's fiscal year 1977 anticipated agenda follows.

A. Budget, Financing, and Reimbursement

A continuing concern of the Council is the funding aspects of the PSRO program. In fiscal year 1976, the budget was approximately \$47 million. In fiscal year 1977 the Congress appropriated \$62 million for PSRO activities. It is estimated that an additional \$27 million will be sent through the Medicare benefit payments for hospital review. This almost doubling of the budget will give the PSRO program greater flexibility to expand its implementation.

Various aspects of the new financing amendments, including the process utilized by delegated hospitals requesting reimbursement, as well as the policies and procedures for funding PSROs through the Medicare trust funds for hospital review, will be concerns of the Council in the coming

year. Other technical aspects of the financing amendments will be continually reviewed and addressed by the Council in fiscal year 1977 activities.

B. Program Implementation

1. Conversion to Conditional and Operational Status

Of immediate primary concern will be the conversion to conditional status of the existing 22 Planning PSROs. Major efforts will also be made during fiscal year 1977 to establish Planning PSROs in the remaining 83 areas of the country that do not have PSROs. These expectations are, of course, dependent on Congressional response to the President's 1977 and 1978 budgets.

2. Project Assessment

A major consideration of the Council will be the project assessment of the existing PSROs, especially the conditionals. The Council will be involved in both the development of the assessment methodology and the actual on-site assessments. Another related task for the Council will be development of criteria and guidelines for determining PSRO conversion from conditional to operational status.

3. Statewide Professional Standards Review (PSR) Councils

In early fiscal year 1977 it is anticipated that there will be six Statewide PSR Councils appointed in California, Maryland, Massachusetts, New York, Pennsylvania, and Connecticut. Later in the year, additional Statewide PSR Councils could be added in other States depending on the outcome of State polls for conversion to single-state areas. The Council will be involved in this activity.

C. Regulations

In the past year, two sets of final regulations, polling and interim hearing and appeals, and a Notice of Proposed Rulemaking for Notification and Polling in Redesignated Areas were published in the Federal Register. During the transitional quarter, final regulations on Advisory Groups to PSROs and Procedures for Designating Statewide Areas were published and a Notice of Proposed Rulemaking was published for Advisory Groups to Statewide PSR Councils. In fiscal year 1977, many other regulations, including Statewide PSR Councils, Confidentiality, Polling, and Area Designation, are to be published following review by the Council.

D. Evaluation

One of the most critical activities of the coming year, and most likely for the next few years, will be the evaluation of the PSRO program. As discussed

in fiscal year 1976 Council meetings, three basic evaluation issues will be addressed in fiscal year 1977. They are 1) evaluation of the impact of concurrent review on hospital utilization, 2) the cost of PSRO and UR activities, and 3) the effectiveness of MCE studies. A special report will be published by the Council in June 1977 on the preliminary assessment of the program's impact. It will cover the first year's operation of both old and new Conditional PSROs.

Another activity related to the PSRO evaluation is the Institute of Medicine Quality Assurance Study. This study contains an evaluative assessment of past and present quality assurance systems, a report of critical gaps in knowledge which require further research and evaluation, a discussion of the implications of the foregoing for quality assessment in the immediate future, and a determination of whether utilization data obtained through hospital use of group discharge abstract services can be used for baseline data in evaluating the impact of the PSRO program. Among the priority areas to be reviewed by the Council are outcome oriented quality assurance systems, quality assurance for long-term care, ambulatory care, impact on physician behavior, cost of conducting review, impact of methods for influencing physician performance, and related quality assurance activities.

The evaluation effort will be an ongoing priority in fiscal years 1977 and 1978.

E. Long-Term Care and Ambulatory Care Review

In the coming year there will be an increased emphasis on the development of ambulatory and long-term care review systems. The focus on long-term care review is a result of a Departmental determination that PSROs can not be converted from conditional to operational status until a long-term care review system is in place. The Council will review long-term care guidelines and discuss the establishment and assessment of various long-term care review programs. In addition, the Council will give particular attention to the fifteen long-term care review demonstration projects which will be undertaken in the coming year.

A strategy similar to the long-term care review demonstrations will be pursued with respect to ambulatory care review.

F. Role of National Professional Standards Review Council in Norms, Criteria, and Standards

In fiscal year 1976 the Council reviewed criteria contracts with a number of major national organizations. Among those discussed by the Council were contracts with the AMA, ANA, AOA, and APA. In the coming year, the Council will address needed modifications in the criteria sets developed under these contracts. One of the important activities of the Council will be the refinement of its role in the actual review and approval of PSRO area norms, criteria, and standards. This will involve the difficult task of determining what is a significant deviation from established models.

G. Data Development

The Council will maintain a major interest in the further development and implementation of PSRO data policy. The PSRO Management Information System will undergo further scrutiny. The Council will also be concerned with the various PSRO data flow models and ongoing data requirements. They will address and monitor policies for data acquisition and systems, confidentiality of information within the PSROs, and minimum data sets needed for both long-term care review and ambulatory care review.

H. Communication With the Public and the Nation's Health Professionals

As indicated in previous national reports, the Council believes it has a special responsibility to communicate the activities of the PSROs to both the public and the nation's health professionals. While this is not a Congressionally mandated function, the Council will continue to assess the need for additional public and professional information and education regarding the PSRO program. The Council's perspective, developed in the background of the legislation and the practical experience in the field of quality assurance activities, will be communicated to those interested both within and outside of the Department of Health, Education, and Welfare.

A critical aspect of this activity is the creation of the previously described liaison network with the non-physician advisory groups who will assist the Council in the PSRO implementation in fiscal year 1977.

MEMBERSHIP

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

July 1, 1975 - June 30, 1976

Clement R. Brown, M.D.
1001 N. Woodbine Avenue
Oak Park, Illinois 60302

Ruth M. Covell, M.D.
Dean's Office, School of Medicine M-002
University of California, San Diego
La Jolla, California 92093

Merlin K. DuVal, M.D.
Vice President for Health Sciences
University of Arizona
Tucson, Arizona 85724

Robert J. Haggerty, M.D.
Harvard School of Public Health
677 Huntington Avenue
Boston, Massachusetts 02115

Donald C. Harrington, M.D.
445 West Acacia Street
P.O. Box 230
Stockton, California 95201

Cornelius L. Hopper, M.D.
Vice President for Health Affairs and
Director, John A. Andrew Clinics
Tuskegee Institute
Tuskegee Institute, Alabama 36088

Robert B. Hunter, M.D.
P.O. Box 429
Sedro Woolley, Washington 98284

Alan R. Nelson, M.D.
2000 South 9th East
Salt Lake City, Utah 84105

Raymond J. Saloom, D.O.
301 Prairie Street
Harrisville, Pennsylvania 16038

Ernest W. Seward, M.D. (Chairman)
Professor of Social Medicine
University of Rochester
School of Medicine & Dentistry
260 Crittenden Boulevard
Rochester, New York 14642

Willard C. Scrivner, M.D.
6600 Main Street
Belleville, Illinois 62223

Executive Secretary
William B. Munier, M.D., M.B.A.
Acting Director
Office of Quality Standards
Room 16A-09, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

Staff Director
William D. Coughlan
Office of Quality Standards
Room 16A-09, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

MEMBERSHIP

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

July 1, 1976 - June 30, 1977

Wyndham B. Blanton, Jr., M.D.
1526 West Avenue
Richmond, Virginia 23220

Ruth M. Covell, M.D.
Dean's Office, School of Medicine M-002
University of California, San Diego
La Jolla, California 92093

Merlin K. DuVal, M.D. (Chairman)
Vice President for Health Sciences
University of Arizona
Tucson, Arizona 85724

Robert L. Hare, M.D.
2232 Northwest Pettygrove Street
Portland, Oregon 97210

Donald C. Harrington, M.D.
555 W. Benjamin Holt Drive
P.O. Box "O"
Stockton, California 95201

Cornelius L. Hopper, M.D.
Vice President for Health Affairs and
Director, John A. Andrew Clinics
Tuskegee Institute
Tuskegee Institute, Alabama 36088

Robert T. Kelly, M.D.
Itasca Clinic
Grand Rapids, Minnesota 55744

Wm. Fred Lucas, M.D.
c/o EDSF
7800 Shoal Creek, #230
Austin, Texas

Alan R. Nelson, M.D.
2000 South 9th East
Salt Lake City, Utah 84105

Raymond J. Saloom, D.O.
301 Prairie Street
Harrisville, Pennsylvania 16038

Willard C. Scrivner, M.D.
6600 Main Street
Belleville, Illinois 62223

Executive Secretary
William B. Munier, M.D., M.B.A.
Director
Office of Quality Standards
Room 16A-09, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Staff Director
William D. Coughlan
Office of Quality Standards
Room 16A-09, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

Meetings in Fiscal Year 1976

<u>Date</u>	<u>Place</u>
July 21-22, 1975	HEW North Building Auditorium (First Floor) Washington, D.C.
September 22-23, 1975	HEW North Building Auditorium (First Floor) Washington, D.C.
November 17-18, 1975	HEW North Building Auditorium (First Floor) Washington, D.C.
January 12-13, 1976	HEW North Building Auditorium (First Floor) Washington, D.C.
March 8-9, 1976	HEW North Building Auditorium (First Floor) Washington, D.C.
May 3-4, 1976	HEW North Building Auditorium (First Floor) Washington, D.C.

TECHNICAL SUBCOMMITTEE

<u>Date</u>	<u>Place</u>
July 21, 1975	HEW North Building Auditorium (First Floor) Washington, D.C.
September 22, 1975	HEW North Building Auditorium (First Floor) Washington, D.C.

NOTE: Meetings of this Subcommittee were
terminated November 17, 1975.

PSRO CONTRACTS

ALABAMA

Single PSRO Area

CONDITIONAL

Alabama Medical Review, Inc.
400 Office Park Drive
Suite 105
Birmingham, Alabama 35223
Phone: (205) 871-3525
Executive Director: Robert King

HSA-105-74-89

ALASKA

Single PSRO Area

CONDITIONAL

Alaska Professional Review Organization
1135 West 8th Avenue, Suite 6
Anchorage, Alaska 99501
Phone: (907) 279-4536
Administrator: Marvin Janzen

HSA-105-74-111

ARKANSAS

Single PSRO Area

CONDITIONAL

Arkansas Foundation for
Medical Care
220 North 12th Street
P.O. Box 1512
Fort Smith, Arkansas 72901
Phone: (501) 785-2471
Medical Director: C.C. Long, M.D.

HSA-105-74-53

ARIZONA

Two PSRO Areas

PLANNING

Area II

Pima Foundation For Medical Care
2343 East Broadway
Suite 204
Tucson, Arizona 85719
Phone: (602) 792-2343
Project Director: Lloyd Epstein

HSA-240-75-90

CALIFORNIA

Twenty-eight PSRO Areas

PLANNING

Area X	Stanislaus-Merced-Mariposa PSRO, Inc. 2030 Coffee Road, Suite A-6 P.O. Box 1755 Modesto, California 95354 Phone: (209) 526-8454 Chief Executive Officer: Paul O. Humbert, Jr.	HSA-105-74-122
Area XV	San Bernardino Foundation PSRO 666 Fairway Drive San Bernardino, California 92408 Phone: (714) 825-8213 Executive Director: Gene Scott	HSA-240-75-94
Area XVI	Organization for PSR of Santa Barbara/San Luis Obispo Counties 9 East Pedregosa Santa Barbara, California 93101 Phone: (805) 965-5275 Project Director: Robert J. Marvin	HSA-105-74-87
Area XXI	California Area XXI PSRO, Inc. 320 W. Foothill Blvd. Monrovia, California 91016 Phone: (213) 359-1141 Project Director: Lorna Amundson	HSA-240-75-92
Area XXIII	California PSRO Area XXIII 3711 Lomita Blvd., Suite 140 Torrance, California 90505 Phone: (213) 378-2248 Medical Director: John M. Wasserman, M.D.	HSA-240-75-97

CONDITIONAL

Area I	Redwood Coast Region PSRO 3416 Mendocino Avenue Santa Rosa, California 95401 Phone: (707) 528-8585 Executive Director:	HSA-105-74-41
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Area III	North Bay PSRO 4460 Redwood Highway, Suite 9 P.O. Box #4344 San Rafael, California 94903 Phone: (415) 472-7771 Executive Director: Janet Connaughton	HSA-105-74-45
Area IV	Greater Sacramento PSRO P.O. Box 13978 Sacramento, California 95813 Phone: (916) 929-1480 Executive Director: Reginald Claytor	HSA-240-75-44
Area V	San Francisco Peer Review Organization, Inc. 250 Masonic Avenue San Francisco, California 94118 Phone: (415) 563-7491 Administrative Director: Tod A. Anderson	HSA-105-74-85
Area VIII	San Joaquin Area PSRO 555 W. Benjamin Holt Drive Suite 421 P.O. Box 1972 Stockton, California 95201 Phone: (209) 951-6711 Executive Director: Dan Sheehy	HSA-105-74-179
Area IX	Santa Clara Valley PSRO 700 Empey Way San Jose, California 95128 Phone: (408) 294-2120 Executive Director: Harlan C. Bennett	HSA-105-74-47
Area XII	Monterey Bay Area PSRO 19040 Portola Drive P.O. Box 308 Salinas, California 93901 Phone: (408) 455-1833 Executive Director: Edgar H. Colvin	HSA-105-74-31
Area XIV	Kern County PSRO, Inc. 1314 17th Street Bakersfield, California 93301 Phone: (805) 327-3711 Executive Director: M.R. Corbett	HSA-105-74-34

Area XVII	Ventura Area PSRO, Inc. 3212 Loma Vista Road Ventura, California 93003 Phone: (805) 647-0750 Administrative Director: .Walter Anderson	HSA-105-74-32
Area XX	California Area XX PSRO 15250 Ventura Blvd. Suite 804 Sherman Oaks, California 91403 Phone: (213) 995-0805 Executive Director: Lila L. Marcus	HSA-240-75-93
Area XXII	California Area XXII PSRO 1100 Glendon Avenue, Suite 1737 Los Angeles, California 90024 Phone: (213) 477-6721 Executive Director: Gerald P. Baldauf	HSA-240-75-86
Area XXIV	Area XXIV PSRO 3200 Wilshire Boulevard, Suite 906 Los Angeles, California 90010 Phone: (213) 389-1267 Medical Director: Rex Greene, M.D.	HSA-105-74-210
Area XXVII	Riverside County PSRO 6833 Indiana Avenue Riverside, California 92506 Phone: (714) 686-0200 Executive Director: Paul S. Parry	HSA-105-74-36
<u>SUPPORT CENTER</u>	United Foundations for Medical Care, Inc. 215 Market Street, Suite 1301 San Francisco, California 94105 Phone: (415) 495-0940 Executive Director: Harold Strunk	HSA-105-74-80

COLORADO

Single PSRO Area

<u>CONDITIONAL</u>	Colorado Foundation for Medical Care 1601 E. 19th Avenue Denver, Colorado 80218 Phone: (303) 534-8580 Executive Vice President: Donald Derry	HSA-105-74-190
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CONNECTICUT

Four PSRO Areas

CONDITIONAL

Area I	PSRO of Fairfield County, Inc. 60 Katona Drive Fairfield, Connecticut 06430 Phone: (203) 576-1214 Executive Director: Mrs. Merrill Ann Weinstein	HSA-105-74-182
Area II	Connecticut Area II PSRO, Inc. 8 Lunar Drive P.O. Box 3907 Woodbridge, Connecticut 06525 Phone: (203) 389-5781 Executive Director: John H. Herder	HSA-105-74-48
Area III	Hartford County PSRO, Inc. 1000 Asylum Avenue Hartford, Connecticut 06105 Phone: (203) 525-5383 Executive Director: Norman Reich	HSA-105-74-55
Area IV	Eastern Connecticut PSRO, Inc. Bridge Street Plaza 41 Bridge Street Willimantic, Connecticut 06226 Phone: (203) 456-2228 Administrative Director: Donald E. Woodbury	HSA-105-74-33

DELAWARE

Single PSRO Area

CONDITIONAL

Delaware Review Organization 1800 Pennsylvania Avenue, Suite 800 Wilmington, Delaware 19806 Phone: (302) 654-4488 Executive Director: Paul L. Gandillot	HSA-105-74-166
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DISTRICT OF COLUMBIA

Single PSRO Area

CONDITIONAL

National Capital Medical
Foundation, Inc.
1828 L Street, N.W., Suite 401
Washington, D.C. 20036
Phone: (202) 223-4422
Executive Director: Norman A. Fuller, Ph.D.

HSA-105-74-29

FLORIDA

Twelve PSRO Areas

PLANNING

Area III

Jacksonville Area PSRO
555 Bishop Gate Lane
Jacksonville, Florida 32204
Phone: (904) 355-9911
Executive Director: C. Art Ellis, Jr.

HSA-240-75-91

CONDITIONAL

Area XII

Dade Monroe PSRO, Inc.
2701 S. Bayshore Drive, Suite 500
Miami, Florida 33133
Phone: (305) 858-6871
Executive Director: Gerard E. Mayer

HSA-105-74-64

GEORGIA

Single PSRO Area

[No Contract Awarded]

HAWAII

(ALSO AMERICAN SAMOA, GUAM, TRUST
TERRITORIES OF THE PACIFIC ISLANDS)

Single PSRO Area

CONDITIONAL

Pacific PSRO, Inc.
320 Ward Avenue, Suite 200
Honolulu, Hawaii 96814
Phone: (808) 536-6980
Project Director: Jon R. Won

HSA-105-74-35

IDAHO

Single PSRO Area

CONDITIONAL

Idaho Professional Standards Review
Organization, Inc.
427 N. Curtis Road
Boise, Idaho 83704
Phone: (208) 377-1910
Executive Director: Ben Kermmoade

HSA-105-74-95

ILLINOIS

Eight PSRO Areas

CONDITIONAL

Area III

Chicago Foundation for Medical Care
10 S. Riverside Plaza, Room 1558
Chicago, Illinois 60606
Phone: (312) 454-0965
Executive Director: William D. Gannon

HSA-105-74-203

Area IV

Quad River Foundation for Medical Care
3033 W. Jefferson Street, Suite 220
Joliet, Illinois 60435
Phone: (815) 744-2425
Executive Director: Myron W. Osborn

HSA-105-74-96

INDIANA

Seven PSRO Areas

PLANNING

Area I Calumet Area Professional Review HSA-105-74-56
 Organization
 2825 Jewett Street
 Highland, Indiana 46322
 Phone: (219) 923-8614
 Executive Director: Charles C. Shoemaker

Area V Indiana Area V PSRO HSA-105-74-121
 2501 Executive Drive, Suite 108
 Indianapolis, Indiana 46241
 Phone: (317) 243-3746
 Executive Director: Arthur G. Loftin

SUPPORT CENTER Indiana Physicians Support Agency HSA-105-74-77
 2501 Directors Row, Suite 106
 Indianapolis, Indiana 46241
 Phone: (317) 243-3229
 Project Director: Wilbert McIntosh, M.D.

IOWA

Single PSRO Area

CONDITIONAL The Iowa Foundation for Medical HSA-105-74-88
 Care, Inc.
 1005 Grand Avenue
 West Des Moines, Iowa 50265
 Phone: (515) 223-1338
 Executive Director: Fred Ferree

KANSAS

Single PSRO Area

PLANNING Kansas Foundation for Medical Care, Inc. HSA-105-74-92
 1300 Topeka Avenue
 Topeka, Kansas 66612
 Phone: (913) 235-2383
 Executive Director: Jerry Slaughter

KENTUCKY

Single PSRO Area

CONDITIONAL

Kentucky Peer Review Organization, Inc.
Professional Towers Building
4010 Dupont Circle, Suite 400
Louisville, Kentucky 40207
Phone: (502) 896-2111
Executive Director: Paul Osborne

HSA-105-74-40

LOUISIANA

Four PSRO Areas

[No Contracts Awarded]

MAINE

Single PSRO Area

CONDITIONAL

Pine Tree Organization for Professional
Standards Review, Inc.
99 Western Avenue
P.O. Box 706
Augusta, Maine 04330
Executive Director: Ronald G. Thurston

HSA-105-74-84

MARYLAND

Seven PSRO Areas

CONDITIONAL

Area I

Western Maryland Review
Organization, Inc.
329 N. Potomac Street
Hagerstown, Maryland 21740
Phone: (301) 733-4440
Executive Director: Charles E. Stevens

HSA-240-75-85

Area II	Baltimore City Professional Standards Review Organization, Inc. 2 Hamill Road, Suite 339 Baltimore, Maryland 21210 Phone: (301) 433-8300 Executive Director: Alvin D. Ankrum	HSA-105-74-62
Area III	Montgomery County, Maryland Medical Care Foundation, Inc. 11141 Georgia Avenue, Suite 510 Wheaton, Maryland 20902 Phone: (301) 942-0900 Executive Director: Ms. Lee Briton	HSA-105-74-49
Area IV	Prince George's Foundation for Medical Care, Inc. 6801 Kenilworth Avenue Berkshire Building, Suite 310 Riverdale, Maryland 20840 Phone: (301) 927-3385 Executive Director: Lawrence D. Stewart	HSA-105-74-194
Area V	Central Maryland PSRO, Inc. 8635 Lock Raven Blvd., Suite 5 Baltimore, Maryland 21204 Phone: (301) 668-5150 Executive Director: Frederick Menosky	HSA-105-74-61
Area VI	Southern Maryland PSRO, Inc. P.O. Box #445 Edgewater, Maryland 21037 Phone: 224-4144 Executive Director: Curtis J. Spicer	HSA-105-74-63
Area VII	Delmarva Foundation for Medical Care, Inc. 108 N. Harrison Street Easton, Maryland 21601 Phone: (301) 822-7223 Executive Director: Peter J. Borchardt	HSA-105-74-57

MASSACHUSETTS

Five PSRO Areas

CONDITIONAL

Area I	Western Massachusetts PSRO, Inc. 103 Van Deene Avenue West Springfield, Massachusetts 01089 Phone: (413) 781-8640 Executive Director: Charles Everett	HSA-105-74-141
Area II	Central Massachusetts Health Care Foundation, Inc. 105 Merrick Street Worcester, Massachusetts 01609 Phone: (617) 798-8667 Executive Director: Richard Kaplan	HSA-105-74-184
Area III	Charles River Health Care Foundation 25 Walnut Street Wellesley Hills, Massachusetts 02181 Phone: (617) 235-5399 Executive Director: Dr. Lewis S. Pilcher, M.D.	HSA-105-74-177
Area IV	Bay State PSRO, Inc. 100 Charles River Plaza Boston, Massachusetts 02114 Phone: (617) 723-2250 Executive Director: Gary M. Janko	HSA-105-74-192
Area V	Southeastern Massachusetts PSRO, Inc. 91 S. Main Street, P.O. Box 676 Middleboro, Massachusetts 02346 Phone: (617) 947-4358 Executive Director: Paul R. Eagan	HSA-105-74-50

MICHIGAN

Ten PSRO Areas

PLANNING

Area VII	Federation of Physicians in Southeastern Michigan 1010 Antietam P.O. Box 125 Detroit, Michigan 48207 Phone: (313) 885-1406 Executive Director: James Long	HSA-240-74-119
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CONDITIONAL

Area I	Upper Peninsula Quality Assurance Association 420 West Magnetic Street Marquette, Michigan 49855 Phone: (906) 228-7685 Executive Director: Bradley Cory	HSA-105-74-159
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Area V	Professional Review Organization - GLSC 920 Metropolitan Building 432 N. Saginaw Street Flint, Michigan 48502 Phone: (313) 233-6071 Executive Director: Donald Blass	HSA-105-74-106
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SUPPORT CENTER

	Michigan PSRO Support Center 120 West Saginaw Street P.O. Box 950 East Lansing, Michigan 48823 Phone: (517) 332-0875 Project Director: Herbert Mehler	HSA-105-74-75
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MINNESOTA

Three PSRO Areas

CONDITIONAL

Area II	Foundation for Health Care Evaluation 20 Washington Avenue, Suite 400 Minneapolis, Minnesota 55401 Phone: (612) 339-6871 Executive Director: Carl G. Gustafson	HSA-105-74-178
Area III	Professional Services Quality Council of Minnesota Room 307 Broadway Hall 102 South Broadway Rochester, Minnesota 55901 Phone: (507) 285-9311 Project Director: Richard W. Hill, M.D.	HSA-105-74-163

MISSISSIPPI

Single PSRO Area

CONDITIONAL

Mississippi Foundation for Medical Care, Inc. P.O. Box 4665 Jackson, Mississippi 39216 Phone: (601) 948-8894 Executive Director: Tom H. Mitchell, M.D.	HSA-105-74-195
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MISSOURI

Five PSRO Areas

CONDITIONAL

Area I	Northwest Missouri PSRO 3044 Gillham Road Kansas City, Missouri 64108 Phone: (816) 531-8432 Project Director: Robert E. Watkins	HSA-105-74-103
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Area II	Mid-Missouri PSRO Foundation 1025 Southwest Blvd. P.O. Box 253 Jefferson City, Missouri 65101 Phone: (314) 634-3321 Executive Director: Thomas Mangus	HSA-105-74-46
Area III	Central Eastern Missouri Professional Review Organization Committee - CEMPROC 4625 Lindell Boulevard, Suite 212 St. Louis, Missouri 63108 Phone: (314) 367-5900 Executive Director: William C. Lindsley	HSA-105-74-65
Area IV	MOAF, Inc 223A Professional Building Springfield, Missouri 65806 Phone: (417) 866-1994 Project Director: N.L. McCartney	HSA-240-75-108
Area V	Southeast Missouri Foundation for Medical Care 234 N. Sprigg Street Cape Girardeau, Missouri 63701 Phone: (314) 334-3016 Executive Director: Mike Kepner	HSA-105-74-197

MONTANA

Single PSRO Area

<u>CONDITIONAL</u>	Montana Foundation for Medical Care 2717 Airport Way, P.O. Box 5117 Helena, Montana 59601 Phone: (406) 443-4020 Executive Director: David Coyner	HSA-240-75-22
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NEBRASKA

Single PSRO Area

[No Contract Awarded]

NEVADA

Single PSRO Area

CONDITIONAL

Nevada PSRO
2305 Sagittarius
Reno, Nevada 89509
Phone: (702) 329-1258
Executive Director: James W. Hand

HSA-105-74-91

NEW HAMPSHIRE

Single PSRO Area

CONDITIONAL

New Hampshire Foundation for
Medical Care
The Durham Road
P.O. Box 658
Durham, New Hampshire 03824
Phone: (603) 868-7410
Director: Constance Azzi

HSA-105-74-105

NEW JERSEY

Eight PSRO Areas

PLANNING

Area VII

Central New Jersey PSRO
The Jefferson Building
330 Miltowne Road
East Brunswick, New Jersey 08816
Phone: (201) 246-8200
Executive Director: Dennis Duffy

HSA-240-75-100

CONDITIONAL

Area I	Professional Standards Review Organization Area I, Region II 2 Shunpike Road Madison, New Jersey 07940 Phone: (201) 377-8100 Executive Director: Frank Mahoney	HSA-105-74-66
Area II	Passaic Valley PSRO 573 Valley Road Wayne, New Jersey 07470 Phone: (201) 696-3730 Executive Director: John Riczko	HSA-105-74-102
Area IV	Essex Physicians' Review Organization, Inc. 144 South Harrison Street East Orange, New Jersey 07018 Phone: (201) 672-0558 Executive Director: Mark Allen	HSA-105-74-30
Area VIII	Southern New Jersey PSRO 203 Barclay Office Pavillion Cherry Hill, New Jersey 08034 Phone: (609) 428-6709 Executive Director: Michael J. Trenn	HSA-240-75-99
<u>SUPPORT CENTER</u>	New Jersey Foundation for Health Care Evaluation 315 West State Street Trenton, New Jersey 08618 Phone: (609) 393-6371 Executive Director: Thomas J. Crane	HSA-105-74-78

NEW MEXICO

Single PSRO Area

<u>CONDITIONAL</u>	New Mexico PSRO 2650 Yale, S.E. Albuquerque, New Mexico 87106 Phone: (515) 842-6236 Executive Director: Jim Buffington	HSA-240-75-03
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NEW YORK

Seventeen PSRO Areas

PLANNING

Area XIV	PSRO of Queens County 112-25 Queens Blvd. Forest Hills, New York 11375 Phone: (212) 793-9700 Executive Director: Mark Rosenblatt	HSA-240-75-89
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CONDITIONAL

Area I	Erie Region PSRO, Inc. 560 Delaware Avenue, Suite 300 Buffalo, New York 14202 Phone: (716) 881-6150 Project Director: Warren A. Mutz	HSA-105-74-86
Area II	Genesee Region PSRO, Inc. 109 South Union Street P.O. Box 1939 Rochester, New York 14603 Phone: (716) 232-5521 Executive Director: John Coleman	HSA-105-74-37
Area III	PSRO of Central New York, Inc. 90 Presidential Plaza Syracuse, New York 13202 Phone: (315) 474-3995 Executive Director: Terrence Dwyer	HSA-105-74-108
Area IV	Five-County Organization for Medical Care & PSR 210 Clinton Road New Hartford, New York 13413 Phone: (315) 735-2204 Executive Director: Peter B. Whitten	HSA-105-74-109
Area V	Adirondack PSRO 52 Park Street Glens Falls, New York 12801 Phone: (518) 793-4667 Executive Director: Conrad S. Kaczmarek	HSA-105-74-51

Area IX	Area 9 PSRO of New York, Inc. Purchase Street Purchase, New York 10577 Phone: (914) 948-4100 Executive Director: Michael J. Maffucci	HSA-105-74-38
Area X	PSRO of Rockland 20 Squadron Blvd. New City, New York 10956 Phone: (914) 634-0505 Executive Director: Jack Cohen	HSA-105-74-118
Area XI	New York County Health Services Review Organization 345 E. 47th Street New York, New York 10017 Phone: (212) 759-1022 Executive Director: Eleanore Rothenberg, Ph.D.	HSA-105-74-44
Area XII	Richmond County, New York PSRO 37 New Dorp Lane Staten Island, New York 10306 Phone: (212) 979-3117 Executive Director: Sheryl Buchholtz	HSA-105-74-107
Area XIII	Kings County Health Care Review Organization 1313 Bedford Avenue Brooklyn, New York 11216 Phone: (212) 467-9000 Executive Director: John Q. Podesta	HSA-105-74-39
Area XV	Nassau Physicians Review Organization 1200 Stewart Avenue Garden City, New York 11530 Phone: (516) 333-4304 Executive Director: Eugene H. O'Reilly	HSA-105-74-164
Area XVI	The Bronx Medical Services Foundation, Inc. 1941 Williams Bridge Road Bronx, New York 10461 Phone: (212) 863-6000 Executive Director: Harry M. Feder	HSA-105-74-165

SUPPORT CENTER

Medical Society of the State of
New York
420 Lakeville Road
Lake Success, New York 11040
Phone: (516) 488-6100
Executive Director: Morton Chalef

HSA-105-74-72

NORTH CAROLINA

Eight PSRO Areas

PLANNING

Area II

Piedmont Medical Foundation, Inc.
325 Stratford Oaks
514 South Stratford Road
Winston-Salem, North Carolina 27103
Phone: (919) 722-9355
Executive Director: William C. Park, Jr.

HSA-105-74-124

SUPPORT CENTER

North Carolina Medical Peer
Review Foundation, Inc.
1100 Navajo Drive
Raleigh, North Carolina 27609
Phone: (919) 872-1856
Director, PSRO Operations: Otto Mueller

HSA-105-74-81

NORTH DAKOTA

Single PSRO Area

CONDITIONAL

North Dakota Health Care Review
3415 N. Broadway
Highway 83 North
Menot, North Dakota 58701
Phone: (701) 852-4231
Administrator: Almon B. Strong

HSA-240-75-98

OHIO

Twelve PSRO Areas

PLANNING

Area VI	Region Six Peer Review Organization 430 Grant Street Akron, Ohio 44311 Phone: (216) 535-5171 Executive Director: Mary Barley	HSA-105-74-152
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CONDITIONAL

Area I	Medco Peer Review, Inc. 204 Lytle Towers 405 Broadway Cincinnati, Ohio 45202 Phone: (513) 421-6112 Executive Director: Edward F. Willenborg	HSA-105-74-125
Area II	Area II Medical Review Organization 30 Fidelity Medical Building 211 South Main Street Dayton, Ohio 45402 Phone: (513) 223-9301 Executive Director: August Sisco	HSA-105-74-135
Area IV	Fourth Ohio Area PSR Council 3550 Secor Road, Suite 202 Toledo, Ohio 43606 Phone: (419) 535-0537 Executive Director: John Mutchler	HSA-105-74-134
Area X	Region X Professional Review Organization 3720 J-Olentangy River Road Columbus, Ohio 43215 Phone: (614) 481-8874 Executive Director: Robert P. Stone	HSA-105-74-131
Area XII	Physicians Peer Review Organization 10525 Carnegie Avenue Cleveland, Ohio 44106 Phone: (216) 421-5900 Executive Director: Donald Mortimer	HSA-105-74-123

SUPPORT CENTER

Medical Advances Institute
1225 Dublin Road
Columbus, Ohio 43215
Phone: (614) 481-8871
President: Edward A. Lentz

HSA-105-74-76

OKLAHOMA

Single PSRO Area

PLANNING

Oklahoma Foundation for Peer Review
5500 North Western, Room 103
Oklahoma City, Oklahoma 73118
Phone: (405) 840-2891
Executive Director: Edward Kelsay

HSA-240-75-96

OREGON

CONDITIONAL

Area I

Multnomah Foundation for Medical
Care
5201 S.W. Westgate Drive, #215
Portland, Oregon 97221
Phone: (503) 297-1704
Executive Director: Philip C. Walker, II

HSA-105-74-168

Area II

Greater Oregon PSRO
2164 S.W. Park Place
Portland, Oregon 97205
Phone: (503) 226-1555
Executive Director: Robert Darnedde

HSA-105-74-52

PENNSYLVANIA

Twelve PSRO Areas

CONDITIONAL

Area II

Central Pennsylvania Area II PSRO
904 Campbell Street
Williamsport, Pennsylvania 17701
Phone: (717) 323-3786
Executive Director: Paul John

HSA-105-74-130

Area IV	Eastern Pennsylvania Health Care Foundation, Inc. 440 S. 15th Street Allentown, Pennsylvania 18102 Phone: (215) 865-1481 Executive Director: William O. Prettyman, Jr.	HSA-105-74-145
Area VI	Allegheny PSRO One Allegheny Square, Suite 630 Pittsburgh, Pennsylvania 15212 Phone: (412) 231-1706 Executive Director: John F. Kuhn	HSA-105-74-161
Area VII	Southwestern Pennsylvania PSRO 825 North Main Street Greensburg, Pennsylvania 15601 Phone: (412) 836-5858 Executive Director: Sandra Levine	HSA-105-74-153
Area VIII	Highlands PSRO Corporation Swank Building, Suite 628 Johnstown, Pennsylvania 15901 Phone: (814) 539-8705 Executive Director: Bernard G. Koval	HSA-105-74-59
Area IX	Southcentral Pennsylvania PSRO 2401 North Fourth Street Harrisburg, Pennsylvania 17110 Phone: (717) 233-0273 Executive Director: Harold Diehl, Jr., FACHA	HSA-105-74-132
Area XI	Montgomery/Bucks PSRO, Inc. 650 Blue Bell West, Suite 209 Skipack Pike Blue Bell, Pennsylvania 19422 Phone: (215) 628-2121 Executive Director: Ralph Rolan, II	HSA-105-74-54
Area XII	Philadelphia PSRO 2100 Spring Garden Street Philadelphia, Pennsylvania 19130 Phone: (215) 567-2792 Executive Director: Tom DiVincenzo	HSA-105-74-162

SUPPORT CENTER

Pennsylvania Medical Care Foundation
20 Erford Road
Lemoyne, Pennsylvania 17043
Phone: (717) 238-1635
Executive Director: Larry R. Fosselman

HSA-105-74-14

PUERTO RICO

Single PSRO Area

PLANNING

Foundation for Medical Care of
Puerto Rico
P.O. Box 13441
Santurce, Puerto Rico 00908
Phone: (809) 725-6969, X240
Executive Director: Osvaldo Lastra, M.D.

HSA-105-74-128

RHODE ISLAND

Single PSRO Area

CONDITIONAL

Rhode Island PSRO, Inc.
(Ripsro, Inc.)
40 Westminster Street, Suite 1730
Providence, Rhode Island 02903
Phone: (401) 331-6661
Executive Director: Edward J. Lynch

HSA-105-74-158

SOUTH CAROLINA

Single PSRO Area

CONDITIONAL

South Carolina Medical Care Foundation
3325 Medical Park Road
P.O. Box 11188, Capital Station
Columbia, South Carolina 29211
Phone: (803) 779-4780
Project Director: William F. Mahon

HSA-105-74-104

SOUTH DAKOTA

Single PSRO Area

CONDITIONAL

South Dakota Foundation for
Medical Care
608 West Avenue, North
Sioux Falls, South Dakota 57104
Phone: (605) 336-3400
Executive Director: Robert Johnson

HSA-105-74-58

TENNESSEE

Two PSRO Areas

PLANNING

Area I

Shelby County Foundation for
Medical Care, Inc.
969 Madison Avenue, Suite 1300
Memphis, Tennessee 38104
Phone: (901) 726-1332
Executive Director: Leon J. Swatzell

HSA-105-74-90

CONDITIONAL

Area II

Tennessee Foundation for Medical
Care, Inc.
Continental Plaza, Suite 300
4301 Hillsboro Road
Nashville, Tennessee 37215
Phone: (615) 385-2444
Executive Director: William D. Tribble, Ph.D.

HSA-105-74-167

TEXAS

Area Designations Pending

[No Contracts Awarded]

UTAH

Single PSRO Area

CONDITIONAL

Utah PSRO
555 East 2nd South, Suite 208
Salt Lake City, Utah 84102
Phone: (801) 532-7545
Executive Director: David Buchanan

HSA-105-74-110

VERMONT

Single PSRO Area

CONDITIONAL

Vermont PSRO, Inc.
P.O. Box 517
Shelburne, Vermont 05482
Phone: (802) 985-8716
Executive Director: Albert C. Stolper

HSA-105-74-143

VIRGIN ISLANDS

Single PSRO Area

[No Contract Awarded]

VIRGINIA

Five PSRO Areas

PLANNING

Area II

Northern Virginia Foundation for
Medical Care
4660 Kenmore Avenue, Suite 320
Alexandria, Virginia 22304
Phone: (703) 370-8707
Executive Director: Gerard G. Coleman

HSA-105-74-133

Area V Colonial Virginia FMC HSA-240-75-83
5 Koger Executive Center, Suite 220
Norfolk, Virginia 23502
Phone: (804) 461-1867
Executive Director: William S. Grant

SUPPORT CENTER Virginia Professional Standards HSA-105-74-73
Review Foundation
Towers Office Building, Room 711
1224 West Main Street
Charlottesville, Virginia 22903
Phone: (804) 977-7211
Executive Director: Leon Geoffrey

WASHINGTON

Single PSRO Area

CONDITIONAL Washington State PSRO HSA-105-74-200
2150 North 107th Street
Suite 504
Seattle, Washington 98133
Phone: (206) 364-9700
Executive Director: Terry G. Kelley

WEST VIRGINIA

Single PSRO Area

CONDITIONAL West Virginia Medical Institute, Inc. HSA-105-74-28
4701 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304
Phone: (304) 925-7011
Acting Executive Director: Betty Kirkwood

WISCONSIN

Two PSRO Areas

CONDITIONAL

Area I	Wisconsin Professional Review Organization 330 East Lakeside Street P.O. Box 1109 Madison, Wisconsin 53701 Phone: (608) 257-6781 Executive Director: Donald McIntyre	HSA-105-74-160
Area II	The Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc. 756 North Milwaukee Street Milwaukee, Wisconsin 53202 Phone: (414) 271-0336 Executive Director: Robert R. Cadmus, M.D.	HSA-105-74-60

WYOMING

Single PSRO Area

CONDITIONAL

Wyoming Health Services Company, Inc. 2727 O'Neil Avenue P.O. Box 4009 Cheyenne, Wyoming 82001 Phone: (307) 635-2424 Executive Director: Robert G. Smith	HSA-105-74-146
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